ASIIS Enrollment Application

(602) 364-3899 or 1-877-491-5741 (toll-free-number)
(602) 364-3285 (ASIIS fax number)

ADHS – Immunization Office/ASIIS
150 North. 18th Avenue, Suite 120
Phoenix, Arizona 85007-3233

(office use only)
IRMS Number: _____

DIRECTIONS: Please fill out the top portion of this form and mail it back to us. If you have any questions, please call us.

Practice Name: _____

Address: _____

City: _____ State: AZ Zip: _____ County_____

Phone #: (_____)_____ FAX #: (_____) _____

Office Manager: _____

E-mail address: _____

Mailing Address (if different than above)

Address: _____

City: _____ State: AZ Zip: _____ County_____

Type of Organization: (**Check only one**)

- ☐ Family or General Practice
- ☐ Pediatrics Practice
- ☐ Family Health Center
- ☐ School-Based Clinic or Family Resource and Wellness Center
- ☐ Indian Health Service Unit (IHS/Tribal Health Center)
- ☐ County Health Department
- ☐ Private Hospital
- ☐ Public Hospital
- ☐ Community Health Center (FQHC)
- ☐ Rural Health Center (RHC)
- ☐ Other (please specify)

Current Computer Hardware Setup:

Do you have a high- speed Internet connection? (This does not include dial –up) ☐ Yes ☐ No

Please note: Internet Explorer 6.0 is required for use of the web application. Internet Explorer is available at www.microsoft.com.

ASIIS USER AGREEMENT

Arizona State Immunization Information System (ASIIS)

ASIIS is a computer based immunization registry and tracking system implemented by the Arizona Department of Health Services and its partners. It is intended to aid health care professionals and other users who have a need to check a client's immunization status according to A.R.S § 36-135, R9-6-707, and R9-6-708. Client-specific information is only available to authorized users and the Arizona Department of Health Services. As a condition for participation in ASIIS, the User enters into this agreement with the Arizona Department of Health Services.

User will use the following methods to report immunization information to the ASIIS Registry:

☐ Web Application (Direct access to the registry via the internet)

☐ ASIIS Paper Reporting Form

☐ Practice Management (PMS) /Billing System /Electronic Medical Record (EMR) /Data Translation Tool (DTT)

If checked: PMS Name:_____ Name of Vendor/Company: _____

Please list the full name(s) of each new and current staff member who will need to use the web application for the purposes of querying and/or entering immunization data. If you are only using the web application to query (look up) records, you only need "view" privileges.

1.	☐ View Privilege ☐ Edit Privilege		4.	☐ View Privilege ☐ Edit Privilege
2.	☐ View Privilege ☐ Edit Privilege		5.	☐ View Privilege ☐ Edit Privilege
3.	☐ View Privilege ☐ Edit Privilege		6.	☐ View Privilege ☐ Edit Privilege

- **View Privilege** means you can only look at the patient record and immunization record(s).
- **Edit Privilege** means you can view, add and make changes to patient and immunization record(s).

Please list all participating health care professionals (e.g., M.D., D.O., N.P.) on the spaces below.

Authorizing Immunization Provider Name		Medical License Number
1.		
2.		
3.		
4.		

1. User agrees to use ASIIS only for the immunization needs of User's clients. User and his/her personnel will access the registry system only when needed to provide health care for User's client(s) or to assess overall immunization status.
2. User is responsible for the actions of User's staff regarding the confidentiality of information contained in the registry system. User shall adhere to the requirements in the ASIIS Confidentiality Policy, which is incorporated by reference into this agreement.
3. User agrees that he/she will safeguard his/her User ID and password against use other than allowed by this agreement. This agreement is in effect for one year and will need to be ***renewed annually*****.**
4. User shall give ASIIS the demographic and immunization information on clients for whom permission has been obtained. User shall submit the immunization information to ASIIS within 30 days of the administered vaccination.
5. User shall allow the parent or guardian to inspect, copy, and if necessary, amend or correct their own children's immunization records. The parent or guardian must demonstrate with proof of a signed official immunization record prior to the information being entered into the user's database and sent to ASIIS.

This agreement is effective January 1st of the current year or when signed and received by the Arizona Department of Health Services, ASIIS program at 150 North 18th Ave, Room 120, Phoenix, Arizona 85007-3233. ASIIS Technical Support Line: (602) 364-3899 or 1-877-491-5741 (toll-free). ASIIS fax: (602) 364-3285.

Primary contact for Immunization Data: _____

(Please Print)

Physician or Office Manager signature: _____ Date _____